# GammAssist Enrollment Form

Enrollee Information (Please Print)

Name | Parent/Guardian Name (if different) | Social Security Number

Street Address | City | State | Zip | Home Telephone Number

E-mail Address | Enrollee Date of Birth | Therapy Start Date

**THERAPY**: ☐ GAMMAGARD S/D IGIV ☐ IVEEGAM EN IGIV

☐ GAMMAGARD LIQUID IGIV ☐ POLYGAM S/D IGIV

Average Monthly Usage

**DIAGNOSIS:** ☐ Immunodeficiency Syndromes ☐ B-cell Chronic Lymphocytic Leukemia (CLL)

☐ Kawasaki Syndrome ☐ Idiopathic Thrombocytopenic Purpura (ITP ☐ Other

Please Specify

## Health Insurance Information

Primary Insurance Carrier ☐Private Insurance ☐Medicare ☐Medicaid

Primary Insurance Company Name | Telephone Number

Subscriber Name | Policy ID

## Physician Information

Physician Name | Telephone Number | Institution/Practice Name | ZIP

**Product Provider:** ☐ Home Care Company ☐ Hospital Out-pt ☐ Physician ☐ Other

Name of Provider | Telephone Number | Contact Name

### Enrollee's Authorization and Certification

I verify that the information provided in this enrollment form is complete and accurate. I authorize PAREXEL (an Independent Program Administrator) to obtain medical and insurance coverage information, as necessary to complete the enrollment process. I have read the conditions of the Program and understand eligibility for this Program is based on certain requirements including continuous use of GAMMAGARD S/D, GAMMAGARD LIQUID, POLYGAM S/D, or IVEEGAM EN. I authorize PAREXEL to obtain information verifying use from home healthcare companies and/or other distributors of Baxter's Immune Globulin Intravenous (Human) therapies. I understand that Baxter reserves the right to deny or approve any Program enrollment form and reserves the right to modify or discontinue the Program at any time.

Please Note: All information and documentation obtained in relation to enrollment n Baxter's GAMMASSIST Program will be held in strict confidence by PAREXEL and will not be shared with Baxter or any other party. For redemption of certificates, a control number will be assigned to each enrollee to assure confidentiality.

Enrollee or Guardian Signature (mandatory for enrollment) | Date

Once the form is completed, mail or fax to:

PAREXEL
P.O. BOX 230906
Centreville, VA 20120
Phone: 800-447-3435 Fax: 888-750-1243